Financing development in the shadow of HIV/AIDS

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TABLE OF CONTENTS

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I. HIV/AIDS: Undercutting Development

With over 26 million accumulated deaths over a 20 year period, HIV/AIDS is the worst epidemic in human history. In 2001 alone an estimated 5 million people, half of whom were young people between the ages of 15 and 24, became infected with HIV. (See Annex 1 for details on the epidemic.) HIV/AIDS has unique and alarming features. Most people who are infected do not know that they carry the deadly virus and may transmit it to others. Earlier devastating epidemics, such as the 14th century European black plague or the early 20th century Spanish flue, behaved like epidemics; they came, ravaged, and faded out. The HIV/AIDS epidemic is likely to be here for a while. However, experience has shown that it can be contained, if enough political commitment, cross-sectoral action and financial resources are ensured.

As the epidemic is still in its early phase, its long-term effects are yet to be seen. But what is clear in the worst affected countries is that HIV/AIDS, while a major humanitarian, health and social disaster, is now having huge economic repercussions. It is creating or aggravating poverty among millions of people, eroding human capital, weakening government institutions and with it the quality of governance and threatening business activities and investment.

There is clear evidence that HIV/AIDS has been transformed into a major multisectoral development concern. Planning and finance ministers are increasingly involved in the formulation of appropriate AIDS policies embracing the respective country's entire development policy. In many countries, Presidents and Prime Ministers have taken the leadership in national AIDS campaigns. In addition to national governments, the business community has become directly involved in the struggle against the epidemic.

More and more, HIV/AIDS is being highlighted in international political and economic fora. For instance:

- The **United Nations General Assembly Special Session on HIV/AIDS** (UNGASS) held in New York in June 2001, resulted in a unanimously approved Declaration of Commitment which emphasizes that the HIV/AIDS challenge cannot be met without new, additional and sustained resources.

- The **United Nations Millennium Summit**, which in September 2000 endorsed eight global development goals one of which specifically addresses the need to halt and reverse the spread of HIV/AIDS by 2015.

- The **United Nations Security Council** which debated HIV/AIDS three times since January 2000 and drew attention to the fact that, if unchecked, the epidemic may pose a risk to stability and security.

- National political commitments made at the highest political level, including in the **Organisation of African Unity (OAU) Summit** held in Abuja, Nigeria in April 2001 where African Heads of State committed to allocating a minimum of 15 per cent of government annual budget to the improvement of the health sector. The Abuja declaration on HIV/AIDS, Tuberculosis and other related infectious diseases also calls for the cancellation of Africa's external debt in favour of increased investment in the social sector.

- Repeated discussions have taken place in meetings of the **Group of Eight (G 8),** including in its meeting in Genoa, Italy in June 2001 where a strong commitment for stepped-up resource mobilisation to fight HIV/AIDS was expressed, illustrating that AIDS has become a key issue for the political leadership of high-income countries, which are also the major donors .

- The annual meetings of the **World Economic Forum** normally held in Davos, Switzerland, have repeatedly had HIV/AIDS on the agenda. At the most recent meeting held in New York in January 2002 prominent business leaders committed themselves to the fight against AIDS as a business priority.

- The **United Nations Conference on the Least Developed Countries** held in Brussels, Belgium, in May 2001 convened a roundtable which discussed AIDS and heard from Ministers of Trade, among others, of the constraints caused by HIV/AIDS to the economic advancement of these countries.

- The Development Committee of the spring meeting of the **World Bank** in Washington, D.C. in 2000, focussed on intensifying action against HIV/AIDS in light of its serious development impact.

- Meetings of the **World Trade Organisation** (WTO) have highlighted the international acceptance that the HIV/AIDS epidemic is a national emergency, have drawn attention to the importance of trade and intellectual property policies in response to the epidemic, and contributed to the decision of the Ministerial Conference in Doha, Qatar in November 2001 to clarify that the WTO agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) does not and should not prevent members from taking measures to protect public health.

II. Costs to development

Contrary to almost all other diseases, HIV/AIDS affects people in their most productive and fertile age, and increasingly affects the younger generation on whom future development depends and for whom a sustainable development basis has to be built. The vast majority of both males and females infected are between 15 and 49 years old. Additional economic losses are imposed on households through income lost by those who have given up their work to look after relatives with AIDS. One person who succumbs to AIDS is likely to increase poverty among several survivors. Given the fact that it is common for both spouses to be infected by HIV/AIDS, many children lose both parents at a young age and the number of orphans is rapidly growing.

AIDS has a profound impact on growth, income and poverty. It is estimated that the annual per capita growth in some countries is falling by 0.5-1.2 percent as a direct result of AIDS. By 2010, per capita GDP in some of the hardest hit countries may drop by 8 percent and per capita consumption even further.

A macroeconomic perspective

Even before the HIV/AIDS epidemic took hold, most of the worst affected countries already had to contend with economic stagnation, a persistent debt crisis and other developmental setbacks. It is still too early too assess the long-term macroeconomic effects of the disease. In the worst affected countries, we have as yet only witnessed an HIV, not an AIDS, epidemic; most of the people who are infected today are still seemingly healthy and remain on their jobs. What is

obvious, however, is that increasing illness and death of large numbers of productive members of society will reduce overall production and consumption.

One macroeconomic effect is that aggregate savings and investment will go down as households become forced to reduce savings. Many business enterprises will also suffer from reduced profits and reduced incentives to invest and expand as AIDS makes the domestic market grow less rapidly. Public savings will also be under severe pressure as tax revenue goes down while pressures mount on the expenditure side. In a study on the likely economic impact of HIV/AIDS in South Africa (ING-Barings, South African Research, 2000), it was estimated that total domestic savings would go down by 15 per cent as a result of HIV/AIDS in the period 2011-2015. The decline in private savings was estimated to account for the lion´s share of the decline.

In the worst affected countries HIV/AIDS acts as a deterrant to foreign direct investment, badly needed to create employment, transfer technology and compensate for the expected drop in domestic savings. Stagnating demand and increased labour costs due to HIV/AIDS are often mentioned as reasons for foreign companies to avoid investing in countries with a high prevalence of HIV/AIDS. Foreign debt problems risk becoming aggravated as the burden of debt payments falls upon a smaller population and a stagnating economy. Interest rates on foreign loans may go up as assessments of country risk take the adverse effects of the epidemic into account.

The public sector

AIDS is causing disruptions to public services in many hard-hit countries through increased morbidity and mortality of employees. The objective of improving governance, already weakened in many countries after years of fiscal austerity, the debt crisis and other problems, will become increasingly difficult to achieve as vital public services and institutions are being eroded by the AIDS epidemic.

Since public sector employees often benefit from various social security schemes - medical and sickness allowances, benefits for surviving spouses and dependents, and others - the costs will increase as the epidemic advances and costs related to HIV/AIDS will increase as a share of total personnel costs.

Other categories of government expenditures in areas such as health and welfare will also need to increase due to HIV/AIDS. At the same time, HIV/AIDS will have an adverse impact on tax revenue as components of the tax base such as personal income, consumption, imports and corporate profits will be reduced. It is estimated that in some countries the government could lose as much as twenty percent of public revenue by 2010 due to the economic impact of HIV/AIDS.

The end result is a drop in the fiscal balance and increasing difficulties in mobilising resources to tackle the HIV/AIDS epidemic and to achieve the goal of good governance, including a stable legal and regulatory framework and an enabling macroeconomic environment. As current expenditure increases, long-term, public investment in physical and social infrastructure is bound to suffer.

The productive sectors

The total demand for goods and services goes down as mortality increases and real incomes fall among AIDS-stricken households, affecting sales and profitability in the productive sectors.

Companies of all types face higher costs in training, insurance, benefits, absenteeism and illness. There are also reports of breakdowns in production, and of failure to meet quality and delivery targets as a result of loss of experienced personnel and high turnover of staff. Vital infrastructural services have sometimes been affected, with adverse effects such as power shortages due to the death of engineers and other key technical staff. Another cost is the loss of transfer of knowledge between more experienced workers and younger employees with companies incurring high recruitment costs to replace employees who can no longer work or die. Some estimates indicate that these costs could add ten per cent or more to the remuneration budget of a typical manufacturing company. This slows private sector development – a core element in the development strategies of many nations.

More than one-third of the gross national product of the worst affected countries come from **agriculture.** Labour-intensive farming systems with a low level of mechanization are particularly vulnerable to HIV/AIDS, although many large-scale, commercial farms in several countries are also suffering from a shortage of agricultural labour and declining productivity. HIV/AIDS is reducing investments in irrigation, soil enhancement and other capital improvements, thereby inhibiting production. The loss of assets, of productive workers and of agricultural investments severely affects the production and purchase of food, affecting long-term food security.

Human capital

Human capital encompasses many variables including the skills, health and productivity of an individual. The **education** sector, for example, is affected by HIV/AIDS in several ways. The number of teachers will fall, in some countries drastically, owing to increased mortality. In some of the most seriously affected countries by HIV/AIDS, for example, it is estimated that over one-quarter of today's school teachers will die from AIDS within the coming decade. It will be difficult to replace them all. The education crisis implies a severe erosion of human capital in the worst affected countries. The crisis is further aggravated if incentives to invest in education are reduced as many young people shorten their time horizons. With life expectancy being reduced by up to 20 years in some countries in sub-Saharan Africa since 1985, the expected rate of return on higher education is perceived to be going down for the individual as well as for society as a whole.

III. Innovative financial mechanisms

The above analysis has indicated that the financing of development cannot be undertaken without consideration of and action on HIV/AIDS in virtually all sectors of development. Investments in development will be largely undercut if AIDS rapidly reverses any advances made. Successful strategies to combat HIV/AIDS are cost-effective, with relatively limited investments in prevention yielding enormous benefits, not only in the form of reduced human suffering, but also in direct costs to economies and societies. Because of the effect of HIV/AIDS on all sectors of development, resources well spent, can not only turn the tide of the epidemic, but preserve the viability of investments in other sectors.

The United Nations General Assembly Special Session on HIV/AIDS set the goal of reaching, by 2005, an overall target of annual expenditure on the epidemic between 7 and 10 billion US dollars. Developed countries were urged to meet the 0,7% target of ODA with 0,15-0,20% destined for Least Developed Countries, taking into consideration the urgency and gravity of the

HIV/AIDS epidemic. Governments further committed themselves to, without further delay, implement the enhanced HIPC Initiative.

Various initiatives, including innovative financing mechanisms to prevent HIV/AIDS and/or deal with its impact are underway by a range of international, national, civil society and private sector groups. These efforts need to be nurtured, supported and sustained, by resources which are additional, since it is necessary to maintain other development investments. Furthermore, engagement by a much broader range of actors needs to be mobilized in order to stem the spread of HIV/AIDS. This includes the financial and business community. While resources are a constraint, so are inadequate financial management systems, limited human capacity, inadequate infrastructure and difficulties in implementation.

Cross-sectoral public-private partnerships

Financing HIV/AIDS programmes will have benefits for both governments and the private sector. Long-term success will depend on strong, mutually beneficial partnerships in a variety of development sectors. These might include, for example, Ministries of Trade in partnership with local federations of business; agricultural ministries in partnership with agribusiness; and, Ministries of Finance in partnership with banking institutions. HIV/AIDS prevention at the company level can yield high financial rates of return to private businesses.

With globalization and increasing cross-border dependence on the production and sale of goods, services and commodities, there is a vast movement of populations for temporary or permanent employment. This migration - both internal and international – has fuelled the spread of HIV/AIDS as people are away from their families for extended periods and have an increased vulnerability to HIV infection. Initiatives in prevention and awareness raising by major companies and corporations working in sectors such as mining, which employ a large number of persons, would be invaluable in reversing this trend.

Successful programmes have demonstrated the importance of bringing in new partners - the business community, NGOs, religious organisations, media, sports organisations and others - in order to join forces and build powerful HIV/AIDS alliances. Countries which have been successful in containing the epidemic have invariably demonstrated a strongly committed political leadership and a flourishing of partnerships between women's groups, faith-based organisations, district authorities, government agencies and private sector entities.

A recent example of a public-private partnership which is expected to generate significant resources for HIV/AIDS is the Global Fund to fight AIDS, tuberculosis and malaria with contributions to date of close to 2 billion US dollars.

Response of Development Banks and International Financial Institutions

International financial institutions, including the World Bank, a Cosponsor of UNAIDS, and regional development banks are today determined to take account of HIV/AIDS in their cooperation with member countries, and are in many cases assisting national governments in the formulation - and implementation - of HIV/AIDS strategies. The explicit inclusion of HIV/AIDS into a large number of Poverty Reduction Strategy Papers (PRSPs) and, in several cases, the attention paid to HIV/AIDS within the highly indebted poor countries (HIPC) initiative for debt relief, also means that HIV/AIDS is becoming an integral part of core budgetary discussions and in the elaboration of overall development policies. A further initiative, the Multi-Country HIV/AIDS Programme for Africa (MAP) of the World Bank, takes

the form of large, zero-interest loans to support African governments, communities and civil society organizations as they implement national multisectoral HIV/AIDS strategies.

All regional development banks are encouraged to highlight HIV/AIDS in their development lending.

If properly elaborated under the ownership of the developing countries, Poverty Reduction Strategy Papers (PRSPs) can help to provide coherence to the scaling-up and reform of national health programmes, within a comprehensive national framework of poverty reduction in which HIV/AIDS programmes must play an important role. This should contribute to placing HIV/AIDS within the framework of each country's key development and budgetary discussions.

Microfinance for support to communities

Poor communities are especially disadvantaged by their inability to access credit. Various innovative microfinance schemes have demonstrated that there is a method for providing viable financial means to help communities. This is especially important for households which have lost the main wage earner to AIDS. Furthermore, people living with HIV/AIDS are frequently discriminated against in the workplace and often loose their employment. Possibilities through microfinance could help to empower persons living with AIDS through creating new opportunities for their financial survival. Creative microfinance partnerships between local financial institutions and the communities in which they operate are urgently needed.

ODA Resources

In middle-income countries most of the resources will come from domestic sources. But most of the worst affected countries are among the poorest in the world, least able to cope with the crisis and finance their HIV/AIDS strategies from domestic resources. On the regional level, it is estimated that up to 80 per cent of total resources needed in Africa and South Asia may have to come from international sources.

Bilateral donors have a special responsibility. The past decade's trend in declining ODA to low-income countries must be reversed, and an increasing share of available resources be directed to activities which have a positive impact on the HIV/AIDS epidemic. The fact that communicable diseases like HIV/AIDS know no national borders means that containing the epidemic is a national ***and*** global concern.

Despite the growing international momentum around HIV/AIDS, available resources are grossly inadequate. In 2002, expenditure on HIV/AIDS programmes in low- and middle-income countries from all sources was estimated to amount to just under US$ 2 billion, i.e. less than one-fifth of projected needs by the year 2005. Unfortunately, resource transfers to developing countries from both public and private sources have stagnated and even declined in recent years. Total ODA to low-income countries has reached its lowest level in two decades. With ODA at present at around 0.25 per cent of GNP in high-income countries, it is very far from the United Nations 0.7 per cent of GNP objective, and moving in the wrong direction. According to UNDP estimates, ODA flows to the 28 countries most seriously affected by AIDS (countries with an adult HIV prevalence rate exceeding four per cent) has fallen by one-third since 1992, from US$ 12.5 billion to US$ 7.8 billion.

According to the Zedillo-report for the Financing for development Conference, ODA would increase by an additional USD 100 billion if the major donors would hour the commitment of

0,7% of GNP in official development assistance. The OECD/DAC estimates that (calculating an average growth in donor countries of 2.5%) an increase from the present ODA-level of some 0,2% to the 0,3% level of some years ago could raise the overall aid resources by 46 billion USD annually to a total of USD 100 billion a year.

Conclusion

HIV/AIDS is undercutting development. Development financing needs to be increased. However, until the spread of the HIV/AIDS epidemic is brought under control, the increase in financing for development will not realise its objectives of achieving the development goals agreed upon at the Millenium Summit. This calls for the engagement of a whole new set of development partners: Ministers of Finance, of Trade, of Planning, of Industry, of Agriculture. It calls for implementing innovative financing mechanisms. It calls for commitments from the business community. It calls for the talents of civil society.

Annex I

The State of the HIV/AIDS Global Epidemic

Twenty years after the first clinical evidence of AIDS was reported, more than 60 million people have been infected with the virus. HIV/AIDS is now the leading cause of death in sub-Saharan Africa. Worldwide, it is the fourth-biggest killer. At the end of 2001, an estimated 40 million people globally were living with HIV. In many parts of the developing world, the majority of new infections occur in young adults, with young women especially vulnerable. About one-third of those living with HIV/AIDS are aged 15-24. Over half a million children under 15 died from AIDS in 2001.

Sub-Saharan Africa remains the region most severely affected by HIV/AIDS. Approximately 3.4 million new infections occurred in 2001, bringing to over 28 million the total number of people living with HIV/AIDS.

Average prevalence in sub-Saharan Africa is today 8.4 per cent in the adult population (15-49 years old). Botswana is the country with the highest rate of infection to date, with 36 per cent of adults infected. In seven countries in Southern Africa more than twenty per cent of adults are infected, and in another nine countries infection rates exceed ten per cent. In several countries, including South Africa where the spread of the epidemic appears to be accelerating, over 30 per cent of all pregnant women are HIV-positive in several areas.

Life expectancy in sub-Saharan Africa is now 47 years, as compared to an estimated 62 years in the absence of AIDS. Decades of improvements in human development are becoming lost. In the worst affected countries, life expectancy may fall below 40 years. In Botswana to 36.

The demographic pyramid changes dramatically. In a short to medium-term perspective the dependency ratio will worsen, as most deaths occur between ages 15 and 49. More children and elderly people will have to be supported by a smaller active labour force.

The number of orphans is increasing rapidly. Today, sub-Saharan Africa is home of more than 95 per cent of the more than 13 million children worldwide who have been orphaned by AIDS.

Next to Africa, the **Caribbean** is the second most affected region in the world, with an average prevalence of 2.2 per cent. In Haiti and Bahamas, the prevalence today exceeds four per cent, and is beginning to have a major impact on demographic, economic and social developments.

The region where HIV/AIDS is growing fastest is **Central Asia and Eastern Europe**. According to conservative estimates the region today registers one million HIV infections. A majority of new infections are related to injecting drug use, but sexually transmitted infections are rising rapidly. In large parts of the former Soviet Union, a number of risk factors are creating a fertile ground for an accelerated spread of the epidemic: rapid social and economic change, a weakening of social capital, rising poverty and inequality, large-scale unemployment, increasing drug use, prostitution and criminality, and deteriorating public health services.

In Asia and the Pacific certain countries - such as Cambodia and Myanmar - and particular regions within countries, register a high rate of HIV prevalence, in particular among high-risk groups such as drug injectors and commercial sex workers. In China and India the overall prevalence is still low, but is rising rapidly. Given the huge populations of these countries, even a low prevalence translates into large numbers of human beings. In India, close to four million people are today HIV positive - more than in any other country besides South Africa. If the rate of infection were to increase to two per cent of India's and China's adult populations, the absolute number of HIV-positive people in these two countries would exceed that of sub-Saharan Africa at present.

In the **Middle East and North Africa**, the trend is towards increasing HIV infection rates, albeit still from very low levels. Injecting drug users and commercial sex workers constitute the major part of people carrying HIV, but there are many "bridges" to the population at large, and outbreaks of HIV infection are occurring outside the high-risk groups. There are also signs that the double disease burden of HIV and tuberculosis is growing in some countries.

In **Latin America**, an estimated 1.4 million people, or 0.5 per cent of the adult population, are living with HIV. The relatively low national prevalence rates in most of Latin America mask the fact that the epidemic is already firmly lodged among specific population groups, in particular in parts of Central America.

In **North America and Western Europe**, the number of new infections has not been reduced significantly in the last decade. In 2001, an estimated 30,000 adults and children became infected with HIV/AIDS in Western Europe and 45,000 in North America. Approximately 1.5 million people in these countries are today living with HIV. A majority of new infections today occur among the poorer strata of the populations. In the rich countries and in many developing countries as well, HIV/AIDS is thus increasingly assuming a prevalence pattern that resembles many other infections, i.e. hitting the poorest hardest.

Global and regional estimates of HIV/AIDS adult prevalence, end 2001, rounded figures

Region	People living with HIV/AIDS (millions)	Adult prevalence (%)
Global	**40**	**1.2**
Sub-Saharan Africa	28	8.4
East Asia and the Pacific	1	0.1
South and South-East Asia	6	0.6
North Africa and Middle East	0.44	0.2
Western Europe	0.56	0.3
Eastern Europe and Central Asia	1	0.5
North America	0.94	0.6
Caribbean	0.42	2.2
Latin America	1.4	0.5
Australia and New Zealand	0.015	0.1

Source: UNAIDS, 2001

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